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8 **BEFORE THE**
BOARD OF REGISTERED NURSING
9 **DEPARTMENT OF CONSUMER AFFAIRS**
10 **STATE OF CALIFORNIA**

11 In the Matter of the Accusation Against:

Case No. 2013-664

12 **RAFAEL ANTONIO LUNA**
11201 5th St., Apt. H106
13 Rancho Cucamonga, CA 91730

A C C U S A T I O N

[Gov. Code, § 11503.]

14 **Registered Nurse License No. 714004**

15 Respondent.

16
17 Complainant alleges:

18 **PARTIES**

19 1. Louise R. Bailey, M.Ed., R.N. ("Complainant") brings this Accusation solely in her
20 official capacity as the Executive Officer of the Board of Registered Nursing ("Board"),
21 Department of Consumer Affairs.

22 2. On or about October 16, 2007, the Board issued Registered Nurse License Number
23 714004 to Rafael Antonio Luna ("Respondent"). The Registered Nurse License was in full force
24 and effect at all times relevant to the charges brought herein and will expire on January 31, 2015,
25 unless it is renewed.

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JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code ("Code") unless otherwise indicated.

4. Section 2750 of the Code states:

"Every certificate holder or licensee, including licensees holding temporary licenses, or licensees holding licenses placed in an inactive status, may be disciplined as provided in this article [Article 3 of the Nursing Practice Act (Bus. & Prof Code, § 2700 et seq.)]. As used in this article, 'license' includes certificate, registration, or any other authorization to engage in practice regulated by this chapter. The proceedings under this article shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code [the Administrative Procedure Act], and the board shall have all the powers granted therein."

5. Section 2764 of the Code states:

"The lapsing or suspension of a license by operation of law or by order or decision of the board or a court of law, or the voluntary surrender of a license by a licentiate shall not deprive the board of jurisdiction to proceed with any investigation of or action or disciplinary proceeding against such license, or to render a decision suspending or revoking such license."

STATUTORY AUTHORITY

6. Section 490 of the Code states, in relevant part:

"(a) In addition to any other action that a board is permitted to take against a licensee, a board may suspend or revoke a license on the ground that the licensee has been convicted of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued.

(b) Notwithstanding any other provision of law, a board may exercise any authority to discipline a licensee for conviction of a crime that is independent of the authority granted under subdivision (a) only if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the licensee's license was issued.

1 (c) A conviction within the meaning of this section means a plea or verdict of guilty or a
2 conviction following a plea of nolo contendere. Any action that a board is permitted to take
3 following the establishment of a conviction may be taken when the time for appeal has elapsed, or
4 the judgment of conviction has been affirmed on appeal, or when an order granting probation is
5 made suspending the imposition of sentence, irrespective of a subsequent order under the
6 provisions of Section 1203.4 of the Penal Code.”

7 7. Section 2761 of the Code states, in relevant part:

8 “The board may take disciplinary action against a certified or licensed nurse or deny an
9 application for a certificate or license for any of the following:

10 (a) Unprofessional conduct, which includes, but is not limited to, the following:

11 ...

12 (d) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the
13 violating of, or conspiring to violate any provision or term of this chapter [the Nursing Practice
14 Act] or regulations adopted pursuant to it.

15 ...

16 (f) Conviction of a felony or of any offense substantially related to the qualifications,
17 functions, and duties of a registered nurse, in which event the record of the conviction shall be
18 conclusive evidence thereof.”

19 8. Section 2762 of the Code states, in relevant part:

20 “In addition to other acts constituting unprofessional conduct within the meaning of this
21 chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this
22 chapter to do any of the following:

23 (a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed
24 physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or
25 administer to another, any controlled substance as defined in Division 10 (commencing with
26 Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as
27 defined in Section 4022.

28 (b) Use any controlled substance as defined in Division 10 (commencing with Section

1 11000) of the Health and Safety Code, or any dangerous drug or dangerous device as defined in
2 Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to
3 himself or herself, any other person, or the public or to the extent that such use impairs his or her
4 ability to conduct with safety to the public the practice authorized by his or her license.

5 (c) Be convicted of a criminal offense involving the prescription, consumption, or
6 self-administration of any of the substances described in subdivisions (a) and (b) of this section,
7 or the possession of, or falsification of a record pertaining to, the substances described in
8 subdivision (a) of this section, in which event the record of the conviction is conclusive evidence
9 thereof.

10 ...

11 (e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any
12 hospital, patient, or other record pertaining to the substances described in subdivision (a) of this
13 section.”

14 9. Section 2765 of the Code states:

15 “A plea or verdict of guilty or a conviction following a plea of nolo contendere made to a
16 charge substantially related to the qualifications, functions and duties of a registered nurse is
17 deemed to be a conviction within the meaning of this article. The board may order the license or
18 certificate suspended or revoked, or may decline to issue a license or certificate, when the time
19 for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an
20 order granting probation is made suspending the imposition of sentence, irrespective of a
21 subsequent order under the provisions of Section 1203.4 of the Penal Code allowing such person
22 to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict
23 of guilty, or dismissing the accusation, information or indictment.”

24 **REGULATORY AUTHORITY**

25 10. California Code of Regulations, title 16, section 1444, states, in relevant part:

26 “A conviction or act shall be considered to be substantially related to the qualifications,
27 functions or duties of a registered nurse if to a substantial degree it evidences the present or
28 potential unfitness of a registered nurse to practice in a manner consistent with the public health,

1 safety, or welfare. Such convictions or acts shall include but not be limited to the following:

2 (c) Theft, dishonesty, fraud, or deceit.”

3 **COST RECOVERY**

4 11. Section 125.3 of the Code provides, in relevant part, that the Board may request the
5 administrative law judge to direct a licentiate found to have committed a violation or violations of
6 the licensing act to pay a sum not to exceed the reasonable costs of the investigation and
7 enforcement of the case. If the administrative law judge makes an award of costs and the licensee
8 fails to comply with the order, the Board may refuse to renew or reinstate the license. (Bus. &
9 Prof. Code, § 125.3, subd. (g)(1).) Pursuant to *Rich Vision Centers, Inc. v. Board of Medical*
10 *Examiners* (1983) 144 Cal.App.3d 110, 110, as codified in Government Code section 11415.60,
11 the Board may recover the reasonable costs of the investigation and enforcement of the case in
12 any stipulated settlement. Code section 125.3, subdivision (i), reserves this settlement authority,
13 notwithstanding the Board’s right to recover costs at a hearing pursuant to a finding of liability.

14 **STATEMENT OF FACTS**

15 12. Los Angeles County-University of Southern California Medical Center (“hospital”)
16 employed Respondent as a nurse in its emergency department from October 2008 to June 2011.
17 Respondent was a travel nurse assigned to the hospital by Around the Clock Staffing, a West
18 Healthcare Services company.

19 13. The hospital uses a Pyxis System to dispense dangerous drugs and controlled
20 substances. The Pyxis machine requires every nurse who withdraws medication to enter a unique
21 identifying code and to associate the transaction with a medical record. The hospital provided
22 Respondent with a unique code to use when making Pyxis transactions.

23 14. Sometime in 2011, the hospital pharmacy audited Respondent’s narcotic withdrawals
24 for the months of April, May and June of that year.

25 15. The audit concluded that Respondent did not account for all of the medication he
26 withdrew.

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1 **DRUG CLASSIFICATIONS**

2 16. Fentanyl is a dangerous drug and a Schedule II controlled substance used for
3 breakthrough pain. (Bus. & Prof. Code, § 4022, Health & Saf. Code, § 11055, subd. (c)(8).)

4 17. Dilaudid is a trade name for hydromorphone, an opium derivative used to treat severe
5 to moderate pain. Dilaudid is a dangerous drug and a Schedule II controlled substance. (Bus. &
6 Prof. Code, § 4022, Health & Saf. Code, § 11055, subd. (b)(1)(J).)

7 18. Lorazepam is an anti-anxiety agent used for the relief of anxiety. It is a dangerous
8 drug and a Schedule IV controlled substance. (Bus. & Prof. Code, § 4022, Health & Saf. Code, §
9 11057, subd. (d)(16).)

10 **FIRST CAUSE FOR DISCIPLINE**

11 **(Unprofessional Conduct—Illegal Possession and Use of a Controlled Substance)**

12 19. Respondent is subject to disciplinary action under Code sections 2761, subdivision
13 (a), and 2762, subdivision (a), for unprofessional conduct in that Respondent illegally obtained,
14 possessed, or used 11,975 micrograms (mcg) of Fentanyl, 4 milligrams (mg) of Dilaudid, and
15 2mg of Lorazepam, each of which is a controlled substance and a dangerous drug. The
16 circumstances are as follows:

17 a. On or about April 4, 2011, Patient 1 presented to the hospital's emergency
18 department. The on-duty physician wrote two orders for Fentanyl 75mcg by intravenous method
19 (IV); the first of which was at 6:13 p.m. and the second of which was at 7:00 p.m. Respondent
20 withdrew 250mcg of Fentanyl from the Pyxis machine at 6:14 p.m. and again at 7:02 p.m.
21 Respondent charted administration of 75mcg of Fentanyl at 6:25 p.m. and again at 6:50 p.m.
22 Respondent failed to account for the remaining 350mcg.

23 b. On or about April 6, 2011, Patient 2 presented to the hospital's emergency
24 department. The on-duty physician wrote an order for Fentanyl 100mcg by IV at 11:30 a.m.
25 Respondent withdrew 250mcg of Fentanyl from the Pyxis machine at 11:36 a.m. and again at
26 2:00 p.m. He charted administration of 100mcg of Fentanyl at 11:40 a.m., but failed to account
27 for the remaining 400mcg.

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1 c. On or about April 7, 2011, Patient 3 presented to the hospital's emergency
2 department. Despite there being no order for Fentanyl, Respondent withdrew 250mcg of the drug
3 from the Pyxis machine under the patient's name at 3:27 p.m. and 4:57 p.m. He charted
4 administration of 75mcg of Fentanyl at 2:19 p.m. and 3:10 p.m., but failed to account for the
5 remaining 350mcg.

6 d. On or about April 14, 2011, Patient 4 presented to the hospital's emergency
7 department. Despite there being no order for Fentanyl, Respondent withdrew 250mcg of the drug
8 and wasted 175mcg of the same at 11:22 a.m. Respondent did not chart administration or
9 otherwise account for the remaining 75mcg.

10 e. On or about April 20, 2011, Patient 5 presented to the hospital's emergency
11 department. The on-duty physician wrote an order for 75mcg of Fentanyl at 11:05 a.m.
12 Respondent withdrew 250mcg of Fentanyl from the Pyxis machine and wasted 175mcg of the
13 same at 11:11 a.m. Respondent withdrew and wasted the same amount (250mcg and 175mcg,
14 respectively) at 1:43 p.m. Respondent then withdrew 250mcg of Fentanyl at 5:00 p.m. and again
15 at 7:31 p.m. He charted administration of 75mcg of Fentanyl at 11:10 a.m. and 3:35 p.m.
16 Respondent withdrew a total of 1,000mcg of Fentanyl and failed to account for the remaining
17 500mcg.

18 f. On or about April 24, 2011, Patient 6 presented to the hospital's emergency
19 department. Despite there being no order for Fentanyl, Respondent withdrew 250mcg of the drug
20 from the Pyxis machine under the patient's name at 7:17 p.m. He wasted 175mcg of the drug and
21 failed to account for the remaining 75mcg.

22 g. On or about April 26, 2011, Patient 7 presented to the hospital's emergency
23 department. Despite there being no order for Fentanyl, Respondent withdrew 250mcg of the drug
24 from the Pyxis machine under the patient's name at 5:21 p.m. and 6:57 p.m. He wasted 175mcg
25 during the last withdrawal and charted administration of 75mcg of Fentanyl at 5:35 p.m.
26 Respondent failed to account for the remaining 250mcg.

27 h. On or about May 4, 2011, Patient 8 presented to the hospital's emergency
28 department. Despite there being no order for Fentanyl, Respondent withdrew 250mcg of the drug

1 under the patient's name at 7:38 a.m., 2:15 p.m., and 5:28 p.m. During the last withdrawal,
2 Respondent wasted 175mcg. He charted administration of 75mcg of Fentanyl at 8:15 a.m., but
3 failed to account for the remaining 500mcg.

4 i. On or about May 12, 2011, Patient 9 presented to the hospital's emergency
5 department. Despite there being no order for Fentanyl, Respondent withdrew 250mcg of the drug
6 under the patient's name at 6:38 p.m. Respondent did not account for this amount of Fentanyl.

7 j. On or about May 13, 2011, Patient 10 presented to the hospital's emergency
8 department. The on-duty physician ordered 50mcg of Fentanyl at 10:50 a.m. Respondent
9 withdrew 250mcg of Fentanyl from the Pyxis machine at 11:36 a.m. and 3:40 p.m. He did not
10 chart administration or otherwise account for the 500 mcg he withdrew.

11 k. On or about May 13, 2011, Patient 11 presented to the hospital's emergency
12 department. The on-duty physician ordered 75mcg of Fentanyl at 7:00 p.m. Respondent
13 withdrew 250mcg of the drug from the Pyxis machine at 7:08 p.m. and 7:31 p.m. He wasted
14 175mcg during the first withdrawal. Respondent charted administration of 75mcg at 7:07 p.m.,
15 but failed to account for the remaining 250mcg.

16 l. On or about May 17, 2011, Patient 12 presented to the hospital's emergency
17 department. The on-duty physician ordered 75mcg of Fentanyl at 1:01 p.m. Respondent
18 withdrew 250mcg of Fentanyl from the Pyxis machine at 1:05 p.m. and 3:40 p.m. Respondent
19 wasted 175mcg during the first withdrawal and charted administration of 75mcg at 3:40 p.m.
20 Respondent failed to account for the remaining 250mcg.

21 m. On or about May 22, 2011, Patient 13 presented to the hospital's emergency
22 department. Despite there being no order for Fentanyl, Respondent withdrew 250mcg of the drug
23 from the Pyxis machine under the patient's name at 7:39 a.m. and 10:38 a.m. He did not chart
24 administration or otherwise account for the 500 mcg he withdrew.

25 n. On or about May 22, 2011, Patient 14 presented to the hospital's emergency
26 department. The on-duty physician ordered 75mcg of Fentanyl at 2:00 p.m. and again at 3:30
27 p.m. Respondent withdrew 250mcg of Fentanyl from the Pyxis machine at 3:40 p.m., 6:38 p.m.,
28 and 6:39 p.m. Of the three withdrawals, totaling 750mcg of Fentanyl, Respondent wasted

1 175mcg and charted administration of 75mcg at 3:30 p.m. He failed to account for the remaining
2 500mcg.

3 o. On or about June 1, 2011, Patient 17 presented to the hospital's emergency
4 department. Although Respondent was not involved in this patient's care, Respondent withdrew
5 250mcg of Fentanyl from the Pyxis machine under the patient's name at 6:40 p.m. Respondent
6 did not chart administration or otherwise account for the 250mcg he withdrew.

7 p. On or about June 1, 2011, Patient 18 presented to the hospital's emergency
8 department. Despite there being no order for Fentanyl, Respondent withdrew 250mcg of
9 Fentanyl from the Pyxis machine under the Patient's name at 7:34 p.m. He did not chart
10 administration or otherwise account for the 250mcg he withdrew.

11 q. On or about June 3, 2011, Patient 19 presented to the hospital's emergency
12 department. The on-duty physician ordered 75mcg of Fentanyl at 3:10 a.m. Although
13 Respondent was not involved in the patient's care, he withdrew 250mcg of Fentanyl at 7:31 a.m.
14 He did not chart administration or otherwise account for the 250mcg he withdrew.

15 r. On or about June 3, 2011, Patient 20 presented to the hospital's emergency
16 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
17 the Pyxis machine under the patient's name at 2:47 p.m. He did not chart administration or
18 otherwise account for the 250mcg he withdrew.

19 s. On or about June 3, 2011, Patient 21 presented to the hospital's emergency
20 department. The on-duty physician ordered 75mcg of Fentanyl at 1:20 p.m. Another nurse
21 administered the medication. Respondent wasted 175mcg of Fentanyl at 3:03 p.m., but failed to
22 account for his possession of the amount he wasted.

23 t. On or about June 3, 2011, Patient 22 presented to the hospital's emergency
24 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
25 the Pyxis machine under the patient's name at 6:31 p.m. He did not chart administration or
26 otherwise account for the 250mcg he withdrew.

27 u. On or about June 4, 2011, Patient 23 presented to the hospital's emergency
28 department. The on-duty physician ordered 25mcg of Fentanyl at 1:30 p.m. Another nurse

1 administered the dose at 1:45 p.m. Respondent withdrew 250mcg of Fentanyl from the Pyxis
2 machine under the patient's name at 4:01 p.m. He did not chart administration or otherwise
3 account for the 250mcg he withdrew.

4 v. On or about June 3, 2011, Patient 24 presented to the hospital's emergency
5 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
6 the Pyxis machine under the patient's name at 7:13 p.m on June 4, 2011. He did not chart
7 administration or otherwise account for the 250mcg he withdrew.

8 w. On or about June 4, 2011, Patient 25 presented to the hospital's emergency
9 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
10 the Pyxis machine under the patient's name at 8:08 p.m. He did not chart administration or
11 otherwise account for the 250mcg he withdrew.

12 x. On or about June 5, 2011, Patient 26 presented to the hospital's emergency
13 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl under
14 the patient's name at 11:36 a.m. He did not chart administration or otherwise account for the
15 250mcg he withdrew.

16 y. On or about June 5, 2011, Patient 27 presented to the hospital's emergency
17 department. The on-duty physician ordered 25mcg of Fentanyl at 2:30 p.m. Respondent
18 withdrew 250mcg of Fentanyl from the Pyxis machine under the patient's name at 1:40 p.m. He
19 did not chart administration or otherwise account for the 250mcg he withdrew.

20 z. On or about June 5, 2011, Patient 28 presented to the hospital's emergency
21 department. The on-duty physician ordered 100mcg of Fentanyl at 5:00 p.m. Respondent charted
22 administration of 100mcg of the drug at 5:02 p.m. He withdrew 250mcg of Fentanyl at 5:04 p.m.,
23 two minutes after he charted administration, and withdrew 250mcg of Fentanyl at 5:51 p.m., but
24 failed to account for the remaining 400mcg.

25 aa. On or about June 5, 2011, Patient 29 presented to the hospital's emergency
26 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
27 the Pyxis machine under the patient's name at 7:45 p.m. He did not chart administration or
28 otherwise account for the 250mcg he withdrew.

1 bb. On or about June 6, 2011, Patient 30 presented to the hospital's emergency
2 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl under
3 the patient's name at 7:20 p.m. He did not chart administration or otherwise account for the
4 250mcg he withdrew.

5 cc. On or about June 6, 2011, Patient 31 presented to the hospital's emergency
6 department. The on-duty physician ordered two 100mcg doses of Fentanyl at 8:06 p.m. Another
7 nurse administered both doses. Respondent withdrew 250mcg of Fentanyl from the Pyxis
8 machine under the patient's name at 9:21 p.m. He did not chart administration or otherwise
9 account for the 250 mcg he withdrew.

10 dd. On or about June 6, 2011, Patient 32 presented to the hospital's emergency
11 department. The on-duty physician ordered 75mcg of Fentanyl at 10:15 p.m. and 100mcg of the
12 drug at 10:55 p.m. Another nurse administered 75mcg of Fentanyl at 10:10 p.m. Respondent
13 withdrew 250mcg of Fentanyl from the Pyxis machine under the patient's name at 11:17 p.m. He
14 did not chart administration or otherwise account for the 250mcg he withdrew.

15 ee. On or about June 9, 2011, Patient 33 presented to the hospital's emergency
16 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
17 the Pyxis machine under the patient's name at 7:20 a.m. He did not chart administration or
18 otherwise account for the 250mcg he withdrew.

19 ff. On or about June 9, 2011, Patient 34 presented to the hospital's emergency
20 department. The on-duty physician ordered 50mcg of Fentanyl at 1:30 p.m., 75mcg at 2:55 p.m.,
21 and 75mcg at 4:40 p.m. Administration was charted at 1:45 p.m., 2:55 p.m., and 4:55 p.m., in the
22 correct amount of the orders. The last administration, at 4:55 p.m., was performed by another
23 nurse. Respondent withdrew 250mcg of Fentanyl from the Pyxis machine at 1:43 p.m.,
24 2:51 p.m., 4:39 p.m., and 7:15 p.m. He wasted 200mcg during the first withdrawal and 175mcg
25 on each of the second and third withdrawals. Respondent withdrew 1,000mcg of Fentanyl,
26 wasted 550mcg, and administered 125mcg. He did not chart administration or otherwise account
27 for the remaining 325mcg.

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1 gg. On or about June 10, 2011, Patient 35 presented to the hospital's emergency
2 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
3 the Pyxis machine under the patient's name at 9:08 a.m. He did not chart administration or
4 otherwise account for the 250mcg he withdrew.

5 hh. On or about June 10, 2011, Patient 36 presented to the hospital's emergency
6 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
7 the Pyxis machine under the patient's name at 10:20 a.m. He did not chart administration or
8 otherwise account for the 250mcg he withdrew.

9 ii. On or about June 10, 2011, Patient 37 presented to the hospital's emergency
10 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
11 the Pyxis machine under the patient's name at 11:46 a.m. He did not chart administration or
12 otherwise account for the 250mcg he withdrew.

13 jj. On or about June 10, 2011, Patient 38 presented to the hospital's emergency
14 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
15 the Pyxis machine under the patient's name at 5:50 p.m. He did not chart administration or
16 otherwise account for the 250mcg he withdrew.

17 kk. On or about June 10, 2011, Patient 39 presented to the hospital's emergency
18 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
19 the Pyxis machine under the patient's name at 7:30 p.m. He did not chart administration or
20 otherwise account for the 250mcg he withdrew.

21 ll. On or about June 12, 2011, Patient 40 presented to the hospital's emergency
22 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
23 the Pyxis machine under the patient's name at 7:44 a.m. He did not chart administration or
24 otherwise account for the 250mcg he withdrew.

25 mm. On or about June 12, 2011, Patient 41 presented to the hospital's emergency
26 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
27 the Pyxis machine under the patient's name at 9:22 a.m. He did not chart administration or
28 otherwise account for the 250mcg he withdrew.

1 nn. On or about June 12, 2011, Patient 43 presented to the hospital's emergency
2 department. Despite there being no order for it, Respondent withdrew 250mcg of Fentanyl from
3 the Pyxis machine under the patient's name at 3:45 p.m. and 5:49 p.m. He did not chart
4 administration or otherwise account for the 500mcg he withdrew.

5 oo. On or about June 13, 2011, Patient 44 presented to the hospital's emergency
6 department. The on-duty physician ordered 75mcg of Fentanyl at 11:55 a.m. An administration
7 of the order was charted at 11:57 a.m. Respondent withdrew 250mcg of Fentanyl from the Pyxis
8 machine at 5:33 p.m., 2mg of Dilaudid at 6:05 p.m., 2mg of Lorazepam at 6:31 p.m., 2mg of
9 Dilaudid at 6:32 p.m., and 250mcg of Fentanyl at 7:48 p.m. Respondent did not chart
10 administration or otherwise account for 500mcg of Fentanyl, 4mg of Dilaudid, and 2mg of
11 Lorazepam.

12 **SECOND CAUSE FOR DISCIPLINE**

13 **(Unprofessional Conduct—Dangerous Use of Controlled Substances and Alcohol)**

14 20. Respondent is subject to disciplinary action under Code sections 2761, subdivision
15 (a), and 2762, subdivision (b), for unprofessional conduct in that Respondent used alcohol and the
16 controlled substances Fentanyl, Dilaudid, and Lorazepam to an extent or in a manner dangerous
17 or injurious to himself and the public. Complainant refers to and by this reference incorporates
18 the allegations set forth in paragraph 19, subparagraphs (a)–(oo), and paragraphs 21–22, as
19 though set forth fully.

20 **THIRD CAUSE FOR DISCIPLINE**

21 **(Conviction of a Substantially Related Offense)**

22 21. Respondent is subject to disciplinary action under Code sections 490 and 2761,
23 subdivision (f), in conjunction with California Code of Regulations, title 16, section 1444, for
24 conviction of a crime substantially related to the qualifications, functions, and duties of a
25 registered nurse. On or about January 17, 2012, Respondent was convicted, upon a plea of *nolo*
26 *contendere*, of one misdemeanor count of reckless driving (Veh. Code, § 23103, subd. (a)). (*The*
27 *People of the State of California v. Rafael Antonio Luna*, Super. Ct. San Bernardino County,
28 2012, No. TWV1101278.) The court sentenced Respondent to thirteen days in jail (with credit

1 for two days), placed him on probation for a period of 36 months, and ordered him to pay fines
2 and restitution and to attend a first-offender alcohol and other drug education and counseling
3 program.

4 22. The circumstances of the conviction are that on or about February 24, 2011,
5 Respondent was observed by California Highway Patrol travelling in excess of the speed limit
6 and swerving over the painted double yellow lines that separate the car pool lane from other
7 traffic lanes. Respondent submitted to a blood test, which returned a result of 0.09 percent
8 alcohol, by weight, in the blood.

9 **FOURTH CAUSE FOR DISCIPLINE**

10 **(Unprofessional Conduct—Conviction Involving Self-Administration of Alcohol)**

11 23. Respondent is subject to disciplinary action under Code sections 2761, subdivision
12 (a), and 2762, subdivision (c), for unprofessional conduct in that Respondent was convicted of a
13 criminal offense involving consumption of alcohol. Complainant refers to and by this reference
14 incorporates the allegations set forth in paragraphs 21–22, as though set forth fully.

15 **FIFTH CAUSE FOR DISCIPLINE**

16 **(Unprofessional Conduct—Falsify Records Pertaining to Controlled Substances and
17 Dangerous Drugs)**

18 24. Respondent is subject to disciplinary action under Code sections 2761, subdivision
19 (a), and 2762, subdivision (e), for unprofessional conduct in that Respondent falsified and made
20 grossly incorrect and grossly inconsistent entries in a record pertaining to controlled substances
21 and dangerous drugs. Respondent repeatedly removed controlled substances and dangerous drugs
22 from the Pyxis machine and associated the withdrawal with patients for whom there was no order.
23 Complainant refers to and by this reference incorporates the allegations set forth in paragraph 19,
24 subparagraphs (a)–(oo), as though set forth fully

25 **SIXTH CAUSE FOR DISCIPLINE**

26 **(Violating Nursing Practice Act and Regulations)**

27 25. Respondent is subject to disciplinary action under Code section 2761, subdivision (d),
28 for violating the Nursing Practice Act and regulations adopted pursuant to it. Complainant refers

1 to and by this reference incorporates the allegations set forth in paragraphs 19–24, as though set
2 forth fully.

3 **SEVENTH CAUSE FOR DISCIPLINE**

4 **(General Unprofessional Conduct)**

5 26. Respondent is subject to disciplinary action under Code section 2761, subdivision (a),
6 for unprofessional conduct. Complainant refers to and by this reference incorporates the
7 allegations set forth in paragraphs 19–25, as though set forth fully.

8 **PRAYER**

9 WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged,
10 and that following the hearing, the Board of Registered Nursing issue a decision:

11 1. Revoking or suspending Registered Nurse License Number 714004, issued to Rafael
12 Antonio Luna;

13 2. Ordering Rafael Antonio Luna to pay the Board the reasonable costs of the
14 investigation and enforcement of this case, pursuant to Business and Professions Code section
15 125.3;

16 3. Taking such other and further action as deemed necessary and proper.

17
18 DATED: February 21, 2013

19 for Louise Bailey
20 LOUISE R. BAILEY, M.ED., R.N.
21 Executive Officer
22 Board of Registered Nursing
23 State of California
24 Complainant
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